SERFF Tracking Number:	*WAKE-126499182*	*State:*	*Arkansas*
Filing Company:	*Life Insurance Company of Alabama*	*State Tracking Number:*	*44855*
Company Tracking Number:	*CMMLOAMAPPAR*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Multiple Application*		
Project Name/Number:	*Life of Alabama/CMMLOAMAPPAR*		

Filing at a Glance

Company: Life Insurance Company of Alabama

Product Name: Multiple Application	SERFF Tr Num: WAKE-126499182	State: Arkansas
TOI: H21 Health - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 44855
Sub-TOI: H21.000 Health - Other	Co Tr Num: CMMLOAMAPPAR	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Toni Hess, Katlyn Gorman, Steve Keck, Chris Moser	Disposition Date: 02/16/2010
	Date Submitted: 02/15/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:
State Filing Description:		

General Information

Project Name: Life of Alabama
Project Number: CMMLOAMAPPAR
Requested Filing Mode:

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 02/16/2010

Deemer Date:
Submitted By: Toni Hess
Filing Description:
RE: Life Insurance Company of Alabama
NAIC Number: 65412
FEIN Number: 63-0321291

SUBMISSION

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 05/20/2009
Domicile Status Comments: The Application was approved for the Disability Forms Form Number HD75109 AL on 5-20-2009 WAKE-126133879
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 02/16/2010
Created By: Chris Moser
Corresponding Filing Tracking Number:

SERFF Tracking Number:	*WAKE-126499182*	*State:*	*Arkansas*
Filing Company:	*Life Insurance Company of Alabama*	*State Tracking Number:*	*44855*
Company Tracking Number:	*CMMLOAMAPPAR*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Multiple Application*		
Project Name/Number:	*Life of Alabama/CMMLOAMAPPAR*		

Life of Alabama Multiple Application Form Number : MPAH309

Wakely Actuarial Services, Inc. has been retained by Life Insurance Company of Alabama to file the above-captioned form on their behalf. We are requesting the review and approval of this form. A letter of authorization is included for reference.

All required filing documents have been completed and are included with the filing.

The filing of this Multiple Application is to be used with previously approved forms which are as follows:
Accident Only Insurance Policy
Policy Form Number HA35A109 AR was approved on 6/15/2009 under SERFF File Number WAKE-126166446
Cancer Indemnity Insurance Policy
Policy Form Number HC75C0109 AR was approved on 6/16/2009 under SERFF File Number WAKE-126070894
Hospital Intensive Care Insurance Policy
Policy Form Number HI75I0109 AR was approved on 4/10/2009 under SERFF File Number WAKE-126070939

Wakely Actuarial Services, Inc. appreciates the Department's time and consideration with this filing.

Company and Contact

Filing Contact Information

Christopher Moser, Compliance Analyst	Chris.M.Moser@hotmail.com
931 Clarmont Avenue	215-500-4269 [Phone]
Bensalem, PA 19020	

Filing Company Information

(This filing was made by a third party - WAS01)

Life Insurance Company of Alabama	CoCode: 65412	State of Domicile: Alabama
302 Broad Street	Group Code: -99	Company Type:
Gadsden, AL 35901	Group Name:	State ID Number:
(256) 543-2022 ext. [Phone]	FEIN Number: 63-0321291	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes

SERFF Tracking Number:	*WAKE-126499182*	*State:*	*Arkansas*
Filing Company:	*Life Insurance Company of Alabama*	*State Tracking Number:*	*44855*
Company Tracking Number:	*CMMLOAMAPPAR*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Multiple Application*		
Project Name/Number:	*Life of Alabama/CMMLOAMAPPAR*		
Fee Explanation:	1 Application - $50.00		
Per Company:	No		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Life Insurance Company of Alabama	$50.00	02/15/2010	34187929

SERFF Tracking Number:	*WAKE-126499182*	*State:*	*Arkansas*
Filing Company:	*Life Insurance Company of Alabama*	*State Tracking Number:*	*44855*
Company Tracking Number:	*CMMLOAMAPPAR*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Multiple Application*		
Project Name/Number:	*Life of Alabama/CMMLOAMAPPAR*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/16/2010	02/16/2010

SERFF Tracking Number:	*WAKE-126499182*	*State:*	*Arkansas*
Filing Company:	*Life Insurance Company of Alabama*	*State Tracking Number:*	*44855*
Company Tracking Number:	*CMMLOAMAPPAR*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Multiple Application*		
Project Name/Number:	*Life of Alabama/CMMLOAMAPPAR*		

Disposition

Disposition Date: 02/16/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*WAKE-126499182*	*State:*	*Arkansas*
Filing Company:	*Life Insurance Company of Alabama*	*State Tracking Number:*	*44855*
Company Tracking Number:	*CMMLOAMAPPAR*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Multiple Application*		
Project Name/Number:	*Life of Alabama/CMMLOAMAPPAR*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Life Insurance Company of Alabama Multiple Application	Approved-Closed	Yes

SERFF Tracking Number:	*WAKE-126499182*	*State:*	*Arkansas*
Filing Company:	*Life Insurance Company of Alabama*	*State Tracking Number:*	*44855*
Company Tracking Number:	*CMMLOAMAPPAR*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Multiple Application*		
Project Name/Number:	*Life of Alabama/CMMLOAMAPPAR*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/16/2010	MPAH309	Application/ Enrollment Form	Life Insurance Company of Alabama Multiple Application	Initial			MPAH309.pdf

APPLICATION FOR ACCIDENT & HEALTH INSURANCE - PART 1

Please Use Dark Ink Suitable for Photocopying.
All Shaded areas must be completed.

Life Insurance Company of Alabama

P. O. Box 349 • Gadsden, Alabama 35902

1. PROPOSED INSURED ☐Married ☐Divorced ☐Widowed ☐Single ☐Separated LAST NAME FIRST M.I.	BIRTHDATE MO	DAY	YR	AGE	STATE OF BIRTH	SEX	SOCIAL SECURITY #	HEIGHT (FT. IN.)	WEIGHT (LBS.)
SPOUSE PROPOSED for INSURANCE									
DEPENDENT CHILDREN PROPOSED for INSURANCE									

2. RESIDENCE ADDRESS STREET	CITY	COUNTY	STATE	ZIP	How long at this address? Years Months If less than 2 years, give previous address in Part 5

PHONE: RES: ( ) BUS: ( )	E-MAIL:

3. INSURED'S EMPLOYER	EMPLOYMENT DATE	OCCUPATION (Describe and give exact duties)

IMPORTANT NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be subject to fines and confinement in prison.

4. Do you have a current Medicaid eligibility card or other state sponsored insurance program? ☐ Yes ☐ No

5. Will the policy applied for replace any insurance in force on any proposed covered person? ☐ Yes ☐ No

6. Health and Disability Insurance in force (if none, so state)
Company *Amount* *Year Issued*

7. Primary Beneficiary & Relationship

7b. Contingent Beneficiary & Relationship

8. PREMIUM MODE & METHOD: Monthly Direct Bill **Not** Available
☐ Annual ☐ Semi Annual ☐ Quarterly ☐ Monthly
☐ Bank Draft ☐ Payroll Deduction ☐ Direct Bill ☐ Family Bill

9. Has any person listed above and proposed for coverage ever tested positive, been diagnosed as having or been treated for acquired immune deficiency syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) in any form? ☐ Yes ☐ No

If "Yes," persons named will be excluded from coverage.

Details of questions answered "Yes," provide question # and name of proposed insured to which history pertains in Part 5 of this application. Persons named may be excluded from coverage.

HOME OFFICE USE

E-Z UNDERWRITING PARTICIPATION REQUIREMENTS

Eligible Fulltime Employees	Minimum For E-Z Underwriting	Eligible Fulltime Employees	Minimum For E-Z Underwriting	Eligible Fulltime Employees	Minimum For E-Z Underwriting	Eligible Fulltime Employees	Minimum For E-Z Underwriting
6	**6**	30	**18**	54	**26**	78	**30**
7	**7**	31	**18**	55	**27**	79	**30**
8	**8**	32	**19**	56	**27**	80	**30**
9	**8**	33	**19**	57	**27**	81	**30**
10	**8**	34	**19**	58	**27**	82	**30**
11	**8**	35	**20**	59	**28**	83	**30**
12	**8**	36	**20**	60	**28**	84	**30**
13	**9**	37	**21**	61	**28**	85	**30**
14	**9**	38	**21**	62	**28**	86	**30**
15	**10**	39	**21**	63	**28**	87	**30**
16	**11**	40	**22**	64	**29**	88	**30**
17	**11**	41	**22**	65	**29**	89	**30**
18	**12**	42	**23**	66	**29**	90	**30**
19	**12**	43	**23**	67	**29**	91	**30**
20	**13**	44	**23**	68	**29**	92	**30**
21	**13**	45	**24**	69	**30**	93	**30**
22	**14**	46	**24**	70	**30**	94	**30**
23	**14**	47	**24**	71	**30**	95	**30**
24	**15**	48	**25**	72	**30**	96	**30**
25	**15**	49	**25**	73	**30**	97	**30**
26	**16**	50	**25**	74	**30**	98	**30**
27	**16**	51	**26**	75	**30**	99	**30**
28	**17**	52	**26**	76	**30**	100	**30**
29	**17**	53	**26**	77	**30**		

HEIGHT AND MAXIMUM WEIGHT CHART

Height	Lump Sum Heart / Heart Stroke Plan	Sickness & Accident Disability Income	Sickness Disability Rider	Inpatient + Outpatient Indemnity Plan
4’10”	160	178	198	198
11”	164	181	201	205
5’ 0”	168	185	205	212
1”	176	190	210	218
2”	180	195	215	227
3”	188	200	220	235
4”	196	206	225	241
5”	202	212	230	248
6”	208	217	236	256
7”	215	222	242	263
8”	222	228	249	271
9”	230	234	256	279
10”	238	240	263	286
11”	246	246	271	293
6’ 0”	254	252	279	297
1”	260	258	287	305
2”	267	265	295	313
3”	273	272	303	321
4”	280	279	311	330
5”	286	287	319	341
6”	293	293	327	351
7”		300	335	360
8”		307	343	368

APPLICATION FOR ACCIDENT & HEALTH INSURANCE - PART 2

CANCER INDEMNITY *☐ Advantage *☐ Choice
Health & Wellness Benefit ☐ $100 ☐ $50
Daily Room ☐ $300 ☐ $200 ☐ $100
Rad. & Chemo. ☐ Option A ☐ Option B ☐ Option C
☐ Individual ☐ Individual/Spouse ☐ 1 Parent ☐ 2 Parent
*Answer Question 11 $_____

First Occurrence Rider ☐ 2 Units ☐ 1 Unit / ☐ Level ☐ Building
☐ Individual ☐ Individual/Spouse ☐ 1 Parent ☐ 2 Parent
$_____

Intensive Care Benefit: I75 ☐ *Rider ☐ ❖Stand Alone
☐ $300 ☐ $450 ☐ $600 ☐ Other _____ $_____
☐ Individual ☐ Individual/Spouse ☐ 1 Parent ☐ 2 Parent
**Answer Question 12* ❖*Answer Question 18*

Specified Disease Benefit Rider* (Dread Disease) $_____
☐ Individual ☐ Individual/Spouse ☐ 1 Parent ☐ 2 Parent
**Answer Question 13* Cancer Indemnity Total $_____

THE MAJOR EXPENSE PLAN *
☐ Lump Sum Cancer & Heart Combo $_____ FACE AMOUNT
☐ Lump Sum Cancer Only $_____ FACE AMOUNT
☐ Lump Sum Heart Only $_____ FACE AMOUNT
☐ Non-Tobacco User ☐ Tobacco User
☐ Dread Disease Rider **Answer Question 13*
☐ Individual ☐ One Parent ☐ Two Parent $_____
Record Height & Weight above for Lump Sum Heart Benefit
**Answer Questions 14 & 16 for Cancer / Questions 15 & 16 for Heart*

Intensive Care Benefit: I63 *
☐ $300 ☐ $450 ☐ $600 ☐ Other _____ $_____
☐ Individual ☐ One Parent ☐ Two Parent
**Answer Question 12* Major Expense Plan Total $_____

HEART STROKE EXPENSE PLAN *
☐ Hospital Confinement Units ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
☐ Dread Disease Rider **Answer Question 13*
☐ Individual ☐ One Parent ☐ Two Parent $_____
**Record Height & Weight above & answer Question 17*

Intensive Care Benefit: I66 *
☐ $300 ☐ $450 ☐ $600 ☐ Other _____ $_____
☐ Individual ☐ One Parent ☐ Two Parent
**Answer Question 12* Heart Stroke Plan Total $_____

INPATIENT + OUTPATIENT HOSPITAL INDEMNITY PLAN✠
☐ Payroll Only Plan (HI67) ☐ Individual Non-Payroll Plan (HI68)
☐ Individual ☐ One Parent ☐ Emp. & Spouse ☐ Two Parent
OPTIONAL BENEFITS: Initial Conf. $_____
Surg. Benefit $_____ Emer. Acc. $_____
Outpat. Sickness $_____ Other $_____
Major Injury (Broken Bones) Units ☐ 1 ☐ 2 ☐ 3 $_____
✠*Record Height & Weight Above & Answer Questions 10(a) & 18* $_____

Intensive Care Benefit: I63 *
☐ $300 ☐ $450 ☐ $600 ☐ Other _____ $_____
☐ Individual ☐ One Parent ☐ Two Parent
**Answer Question 12* Inpatient + Outpatient Plan Total $_____

ACCIDENT INCOME PROVIDER * ☐ $3000 ☐ $1500
SENIOR ACC. INCOME PROVIDER * ☐ $3000 ☐ $1500
☐ Individual ☐ One Parent ☐ Two Parent ☐ Two Adult
**Answer Question 10(a)* Accident Income Provider Total $_____

ACCIDENT DISABILITY PLAN * (90 Day Employment Required)
Pre-Packaged Plan ☐ 400 ☐ 600 ☐ 800 ☐ 1000 ☐ 1200
Applicant's Gross Monthly Income $_____
☐ 24 Hour Coverage ☐ Off-The-Job Only
☐ Emp ☐ Emp/Sp ☐ Emp/Ch ☐ Emp/Fam $_____
**Answer Question 10(a)*

✦**BUILD A PLAN** Monthly Income $_____ FACE AMOUNT
Applicant's Gross Monthly Income $_____
☐ 24 Hour Coverage ☐ Off-The-Job Only
Benefit Period ☐ 6 months ☐ 1 Year
Accident Elimination Period ☐ 0 ☐ 7 ☐ 14 Days
☐ Emp ☐ Emp/Sp ☐ Emp/Ch ☐ Emp/Fam $_____
**Answer Question 10(a)* ✦*Does not apply to Packaged Accident Disability Plans*

✠Sickness Disability Rider Mo. Inc. $_____ FACE AMOUNT
Benefit Period ☐ 6 month ☐1 year
Elimination ☐7 or ☐14 days ☐30 days $_____
✠*Record Height & Weight Above & Answer Question 18*

SICKNESS & ACCIDENT DISABILITY INCOME PLAN *
☐ Standard ☐ Preferred (90 Day Employment Required)
❖Monthly Disability Benefit $ _____ FACE AMOUNT
Applicant's Gross Monthly Income $ _____
Benefit Period ☐ 3 months ☐ 6 months ☐ 1 Year ☐ 2 Years
Accident Elimination Period ☐ 0 ☐ 7 ☐ 14 Days
Sickness Elimination Period ☐ 7 ☐ 14 ☐ 30 ☐ 60 ☐ 90 ☐ 180 Days
✠*Record Height & Weight Above & Answer Questions 10(a) and 18*
$ _____

Optional Benefits for Sickness &/or Accident Disability Plan:
Level of coverage (i.e. Emp, Emp/Sp, Emp/Ch, Emp/Fam) for optional benefits is determined by the level of coverage selected for base policy.

☐ ✦Initial Hospital Confinement Benefit $1000 $_____

✦Injury Treatment Benefit $_____
☐ $100 ☐ $150 ☐ $200 ☐ $250 ☐ $300

☐ ✦Health Screening Benefit $_____

☐ Supplemental Injury Benefit $_____

☐ **Specific Loss Rider (Broken Bone)** $_____

Intensive Care Benefit* I75 $_____
☐ $300 ☐ $450 ☐ $600 ☐ Other _____
**Answer Question 12*
✦*Does not apply to Pre-Packaged Accident Disability Plans*
Sickness &/or Accident Disability Income Plan Total $_____

APPLICATION FOR ACCIDENT & HEALTH INSURANCE - PART 3

Details of questions answered "Yes," provide question # and name of proposed insured to which history pertains in Part 5 of this application. Persons named may be excluded from coverage.

10a. Is any proposed insured currently in the hospital or receiving disability payments? Yes ☐ No ☐

Answer 10(b) when offering a plan approved for E-Z Underwriting

10b. *In the past 5 years has any proposed insured had any known indication of or been treated for a heart attack, internal cancer, melanoma, disease or disorder of the lungs or hepatitis?* Yes ☐ No ☐

11. CANCER ADVANTAGE & CHOICE

Answer Question 14 for The Major Expense Plan (Lump Sum Cancer)

11a. Has any person proposed for coverage under this Policy within the last 24 months, had any elevated or rising PSA or CEA test or abnormal mammogram, pap smear, radiological exam (e.g. X-Ray, MRI, CAT Scan), biopsy or scope procedure (e.g. colonoscopy, endoscopy, etc.)? Yes ☐ No ☐

11b. Has any person proposed for coverage under this Policy **within the last five years**, been diagnosed as having or been treated for any cancer, including skin cancer, Hodgkin's Disease and Leukemia, in any form? Yes ☐ No ☐

11c. Has any person proposed for coverage under this Policy been diagnosed, as having or been treated for any cancer, including skin cancer, Hodgkin's Disease and Leukemia, in any form **over five years ago**? Yes ☐ No ☐

If yes to question 11a or b any person(s) so designated will not be covered under the policy.

If yes to question 11c, you are eligible for a policy that provides Option C Radiation & Chemotherapy Benefits and $100 per day Daily Room Benefit for the treatment of cancer. No additional amounts will be issued.

12. INTENSIVE CARE: Has any proposed insured ever been diagnosed or treated for heart disease, heart attack, any heart condition, heart trouble or any abnormality of the heart? Yes ☐ No ☐

(b) If this is a Two Parent Family Policy/Rider, is any person to be insured currently pregnant or taking fertility drugs? Yes ☐ No ☐

(c) If this is a One Parent Family Policy/Rider, are you, your fiancee or companion currently pregnant or taking fertility drugs? Yes ☐ No ☐

If yes to question (b) or (c), we will issue an individual policy / rider on the adult male family member only.

Answer Question 18 for Intensive Care Stand Alone Policy

Details of questions answered "Yes," provide question # and name of proposed insured to which history pertains in Part 5 of this application. Persons named may be excluded from coverage.

13. SPECIFIED DISEASE:

Has any person proposed for coverage under this Policy ever had treatment or diagnosis of: • Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease) • Botulism • Bubonic Plague • Cerebral Palsy • Cholera • Cystic Fibrosis • Diphtheria • Encephalitis (including encephalitis contracted from West Nile virus) • Huntington's Chorea • Lyme Disease • Malaria • Menningitis (Bacterial) • Multiple Sclerosis • Muscular Dystrophy • Myasthenia Gravis • Necrotizing Fasciitis • Osteomyelitis • Polio • Rabies • Reye's Syndrome • Rheumatic Fever • Rocky Mountain Spotted Fever • Scleroderma • Sickle Cell Anemia • Smallpox • Systemic Lupus • Tetanus • Toxic Shock Syndrome • Tuberculosis • Tularemia • Typhoid Fever • Variant Creutzfeldt-Jakob Disease (Mad Cow Disease)• Yellow Fever? Yes ☐ No ☐

14. MAJOR EXPENSE PLAN (Lump Sum Cancer)**:**

(a) Has any person proposed for coverage under this Policy within the last 24 months, had any elevated or rising PSA or CEA test or abnormal mammogram, pap smear, radiological exam (e.g. X-Ray, MRI, CAT Scan), biopsy or scope procedure (e.g. colonoscopy, endoscopy, etc.)? Yes ☐ No ☐

(b) Has any person proposed for coverage under this Policy ever been diagnosed as having or been treated for cancer, including skin cancer, Hodgkin's Disease and Leukemia, in any form? Yes ☐ No ☐

Answer Question 16

15. MAJOR EXPENSE PLAN (Lump Sum Heart)**:**

(a) Has any person proposed for coverage under this Policy ever been diagnosed as having or ever been treated for any of the following conditions in any form: (a) myocardial infarction or heart attack; (b) any disease, disorder or abnormality of the heart or coronary arteries, or any heart related condition; or (c) stroke or transient ischemic attack (TIA); or (d) diabetes; or (e) lung disease? Yes ☐ No ☐

(b) Has any person proposed for coverage under this Policy ever had or ever been advised to have: (a) any form of heart surgery, coronary artery surgery, or heart related surgery; or (b) an arteriogram, angioplasty, or pacemaker installed? Yes ☐ No ☐

Record Height & Weight of all proposed for coverage in Part 1 and/or 4 of Application and answer Question 16

16. HAS ANY PERSON proposed for insurance in Part 1 on reverse side used tobacco in any form within the past 24 months? (If yes, give name and details in Part 5 of this application) Yes ☐ No ☐

Details of questions answered "Yes," provide question # and name of proposed insured to which history pertains in Part 5 of this application. Persons named may be excluded from coverage.

APPLICATION FOR ACCIDENT & HEALTH INSURANCE - PART 4

17. HEART STROKE EXPENSE PLAN:

(a) Has any person proposed for coverage under this Policy ever been diagnosed as having, been treated for, received medical advice, or taken prescription medication for High Blood Pressure? Yes ☐ No ☐

If NO to question (a), proceed with questions b through d.

If YES to question (a), answer question (a1).

(a1) Has any person proposed for coverage used tobacco in any form within the past 24 months? Yes ☐ No ☐

If YES to question (a1), coverage for that insured will be declined.

If NO to question (a1), proceed with questions b through e.

(b) Has any person proposed for coverage under this Policy ever been diagnosed as having, or been treated for, received medical advice or taken prescription medication for Stroke, transient ischemic attack (TIA), or any disease, disorder or abnormality of the brain or circulatory system (arteries, veins, lymph nodes, and vessels) (a) myocardial infarction or heart attack; (b) any disease, disorder or abnormality of the heart or coronary arteries, or any heart related condition? Yes ☐ No ☐

(c) Has any person proposed for coverage under this Policy ever been diagnosed as having, been treated for, received medical advice or taken prescription medication for: (a) diabetes; or b) lung or respiratory system disease or disorder? Yes ☐ No ☐

(d) Has any person proposed for coverage under this Policy ever had or been advised to have: (a) any form of heart surgery, coronary artery surgery, or heart related surgery; (b) an arteriogram, angioplasty, or pace maker installed? Yes ☐ No ☐

If YES to questions (a1), (b), (c) or (d), coverage for that insured will be declined.

Record Height & Weight of all proposed for coverage in Part 1 of Application

Details of questions answered "Yes," provide question # and name of proposed insured to which history pertains in Part 5 of this application. Persons named may be excluded from coverage.

NOTE: Question 18 must be answered when applying for:

- **Inpatient + Outpatient Medical Expense Plan**
- **Intensive Care Stand Alone Policy**
- **Sickness Disability Rider** and
- **The Sickness and Accident Disability Income Plan**

unless approved for E-Z Underwriting.

Details of questions answered "Yes," provide question # and name of proposed insured to which history pertains in Part 5 of this application. Persons named may be excluded from coverage.

18. HAS ANY PERSON to be covered ever had or been told or been treated for:

(a) Had any application or policy for life or health insurance been declined, special rated, restricted, postponed, cancelled or reinstatement denied? Yes ☐ No ☐

(b) Had driver's license suspended or revoked in past 24 months? Yes ☐ No ☐

(c) Disease or disorder of the heart or blood vessels, chest pain, high or low blood pressure? Yes ☐ No ☐

(d) Disease or disorder of the nervous system to include mental disorder, epilepsy or paralysis? Yes ☐ No ☐

(e) Disease or disorder of the respiratory system to include emphysema or asthma? Yes ☐ No ☐

(f) Disease or disorder of stomach, liver, intestines, bladder, kidney, or reproductive organs, hemorrhoids or hernia? Yes ☐ No ☐

(g) Cancer, tumor, diabetes, Leukemia, gland or blood disorders? Yes ☐ No ☐

(h) Alcohol or drug usage or abuse? Yes ☐ No ☐

(i) Is any person to be covered, currently pregnant or taking fertility drugs? Yes ☐ No ☐
(If yes, answer question 12 b & c)

(j) Within the last five years, has any person to be covered had any ailment of the back? Yes ☐ No ☐

(k) Had any other medical advice, treatment or surgery not already listed? Yes ☐ No ☐

(l) Is proposed primary insured working at least 30 hours per week? Yes ☐ No ☐

DETAILS of questions 9-18 answered "yes" including question number, names and addresses of physicians and individuals to whom history pertains, should be listed in Part 5 of this Application.

APPLICATION FOR ACCIDENT & HEALTH INSURANCE - PART 5

DETAILS of questions 9-18 answered "yes" including question number, names and addresses of physicians & individuals to whom history pertains.

If the proposed insured and any children proposed for insurance are deemed to be insurable at standard rates, the insurance shall become effective on the date hereof, otherwise the insurance shall not take effect until a policy is issued and the first premium paid.

CERTIFICATION- The Applicant hereby makes application to Life Insurance Company of Alabama for a policy or policies of insurance and represents that the statements and answers set forth under Parts 1, 2, 3, 4 and 5 of this application by whomsoever written, are full, complete and true to the best of Applicant's knowledge and belief and agrees that they shall be considered as the basis of any insurance which may be issued hereon. The undersigned applicant and agent acknowledge that the applicant has read, or had read to him/her, the completed application and that he/she realizes that policy issuance is based upon statements and answers provided herein.

AUTHORIZATION- By this form (or a photographic copy of it), I authorize any licensed physician, medical practitioner, clinic hospital, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or knowledge of anyone proposed for coverage for whom insurance application is made, to give to The Life Insurance Company of Alabama, or it's reinsurers, any such information and to testify as to such information, all to the extent permitted by law. Should my application for insurance be denied due to an adverse underwriting decision, I have the right to obtain this information from Life Insurance Company of Alabama. I may request this information in writing within 90 business days from the date I am notified of such a decision. Life Insurance Company of Alabama must respond to my request within 21 days from the date of receipt of my request. I also acknowledge that I have received the Investigative Consumer Reports notification and Important Notice attached to this application. This authorization shall be valid for 30 months from the date it is signed.

As normal procedure, the Home Office Underwriting Department may contact you by telephone to verify pertinent information contained in your application. What is the best way to reach you?

Home/Office Phone:
Cell Phone:
Email address:

I, the agent, hereby certify by my signature below that, I have truly and accurately recorded on this application the information supplied by the applicant.

X _____
Witness (Licensed Resident Agent, if required)

X _____
Agent Agent's No.

X _____
Agent Agent's No.

AGENT'S STATEMENT: To the best of your knowledge does this insurance replace any existing insurance? ☐ Yes ☐ No
If Yes, give name of company and policy number.

Arkansas Only:
No person to be covered for specified disease is also covered by any Title XIX program Medicaid or similar coverage.
☐ Yes ☐ No

Signed at _____
City State

Date _____
Month Day Year

X_____
Signature of Proposed Primary Insured

X_____ - -
Signature of Owner or Other Insured Social Security or Tax ID #

BILLING DATA AND PAYROLL DEDUCTION AUTHORIZATION

PART I - REQUIRED ON EACH SALARY SAVINGS POLICY (***PLEASE PRINT OR TYPE***)

EFFECTIVE DATE	NAME OF EMPLOYEE	SOCIAL SECURITY NO.
DEPT. NO.	NAME OF EMPLOYER	MONTHLY PREMIUM
EMP. NO.	INDICATE TYPE OF COVERAGE	WEEKLY PREMIUM

PART II - REQUIRED IF A PREMIUM IS TO BE PAID BY EMPLOYEE

I hereby request and authorize you to deduct the premium from my wage and to transmit it to Life Insurance Company of Alabama (LICOA). These deductions are to cover the premiums on the insurance policy I have applied for if the policy is issued by LICOA.

I acknowledge that this authorization is being signed at the same time I am applying for insurance coverage with LICOA, but IN NO EVENT WILL ANY INSURANCE BE IN FORCE UNTIL THE EFFECTIVE DATE OF ANY POLICY WHICH MAY BE ISSUED BY LICOA. This authorization also allows you to increase my deduction for any premium increases on the policy which may be made by LICOA.

_____ **X** _____

DATE SIGNATURE OF EMPLOYEE

AUTHORIZATION TO HONOR CHECKS DRAWN BY AND PAYABLE TO THE LIFE INSURANCE COMPANY OF ALABAMA, GADSDEN, ALABAMA

To _____Bank

Branch Name , if any_____

Bank Address_____

As a convenience to me, I hereby request and authorize you to pay and charge to my bank checking account checks drawn by and payable to the order of the Life Insurance Company of Alabama, Gadsden, Alabama provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any officer or employee of The Life Insurance Company of Alabama to sign such checks. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

_____ _____ **X** _____

Date Bank Account Bank Signature of Depositor

Cut along dotted line.

IMPORTANT NOTICE

The underwriting process (evaluation and classification of risks) is necessary to assure reasonable cost of insurance and provide a mechanism by which policyholders pay their fair share of the cost. In considering your application, information from various sources is considered, including your own statements, the results of your physical examination (if required), and any reports we obtain from doctors or medical facilities where you have been attended.

Information regarding your insurability will be treated as confidential. We or our Reinsurers may, however, make a brief report thereon to the MIB, Inc. formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642.) If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

We or our reinsurers may release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. The purpose of the bureau is to protect its members and their policyholders from the extra expense created by those who omit or conceal information relevant to their insurability. Information furnished by the Bureau may serve to alert the company to a need for further investigation but under Bureau rules cannot be used either wholly or partly as the basis for increasing the charge for or denying the issuance of insurance. Information in the Bureau gives no indication regarding the action taken on an application (i.e., whether accepted standard, accepted with increased premium, or declined).

Should your application for insurance be denied due to an adverse underwriting decision, you have the right to obtain this information from Life Insurance Company of Alabama. You may request this information in writing within 90 business days from the date you are notified of such a decision. Life Insurance Company of Alabama must respond to your request within 21 days from the date of receipt of your request. You may request this information by writing to the Manager - Individual Policy Department at Life Insurance Company of Alabama, P.O. Box 349, Gadsden, AL 35902 or through our field representative.

INVESTIGATIVE CONSUMER REPORTS

Under Public Law 91-508, we are required to inform persons proposed for insurance that, as part of our regular underwriting procedure, an investigative consumer report may be obtained, which will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with your friends, neighbors, and associates. Upon written request to the Manager-Individual Policy Department at Life Insurance Company of Alabama, P.O. Box 349, Gadsden, Alabama 35902, further information on the nature and scope of the report will be provided.

Date _____ _____
Signature of Proposed Primary Insured

Date _____ _____
Signature of Applicant or Owner,
if other than Proposed Insured

THIS NOTIFICATION MUST BE DELIVERED TO THE PERSON NAMED ABOVE.

Life Insurance Company of Alabama
Home Office, Gadsden, Alabama

Cut along dotted line.

To: The Bank named on the reverse side.
Life Insurance Company of Alabama agrees:

(1) To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.

(2) In the event that any such check, draft or order shall be dishonored whether with or without cause and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.

(3) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

LIFE INSURANCE COMPANY OF ALABAMA, Gadsden, Alabama

Wayne W. Daughtry
President

Authorized in resolution adopted by the Executive Board of
The Life Insurance Company of Alabama on April 29, 1974

SERFF Tracking Number:	*WAKE-126499182*	*State:*	*Arkansas*
Filing Company:	*Life Insurance Company of Alabama*	*State Tracking Number:*	*44855*
Company Tracking Number:	*CMMLOAMAPPAR*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Multiple Application*		
Project Name/Number:	*Life of Alabama/CMMLOAMAPPAR*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	02/16/2010

Comments:

Attachments:

Arkansas Rule 19.pdf

Arkansas Rule 49.pdf

Consumer Notice.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	02/16/2010
Bypass Reason:	See General information tab - Application attached in Forms Tab		

Comments:

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	02/16/2010
Bypass Reason:	Not Applicable - Application Filing		

Comments:

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	02/16/2010
Bypass Reason:	Not Applicable - Application Filing only		

Comments:

Arkansas
Rule and Regulation 19 Certification

Title of Form(s)	Form Number
Application	MPAH309

I Hereby certify that the above noted forms meet the provisions of Rule and Regulation 19, the Unfair Sex Discrimination in the State of Insurance.

Signature

Christopher M. Moser
Name

Compliance Analyst
Title

Arkansas
Rule and Regulation 49 Certification

Title of Form(s)	Form Number
Application	MPAH309

I Hereby certify that the above noted forms meet the provisions of Rule and Regulation 49, the Life & Health Guaranty Association Notice.

Signature

Christopher M. Moser
Name

Compliance Analyst
Title

Consumer Notice
Life Insurance Company of Alabama

Policyholder Service Office:	**302 Broad Street** **Gadsden, AL 39901**
Telephone Number:	**256-543-2022**
Name of Agent:	**[Fred Smith]**
Agent Address:	**[123 First Street, Any Town, Arkansas]**
Agent Telephone Number:	**[555-555-1234]**

If we at Life Insurance Company of Alabama fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
1-800-852-5494 or 1-501-371-2460